E-mail notice sent to all Hospital Data Reporting Contacts on November 8, 2006

Subject: Hospital Discharge Data Update - Nov 2006 ICD Coding Guidelines

The purpose of this notification is to address some of the changes to the ICD-9-CM Official Guidelines for Coding and Reporting (Guidelines), which go into effect on November 15, 2006. Specifically, there are changes in the Guidelines related to E code assignment, and it is anticipated that these changes may cause some confusion regarding what is, or is not, required by the Arizona Department of Health Services (ADHS).

As you are all aware, E codes are not required for billing purposes, but *are* required by the State of Arizona. In the interest of adhering to an established national standard, ADHS recognizes the Guidelines as the authoritative source for issues related to coding. However, the recent changes to the Guidelines regarding E codes appear somewhat ambiguous. For this reason, ADHS is providing information on this issue, specific to Arizona hospital discharge data reporting.

As stated in the Guidelines, "*External causes of injury and poisoning codes (E codes) are intended to provide data for injury research and evaluation of injury prevention strategies. E codes capture how the injury or poisoning happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), and the place where the event occurred*." The reporting of appropriate E codes is extremely important, but it is equally important to refrain from redundant E code reporting. Simply put, duplicative E coding not only makes additional work for coders, but it also degrades the quality of the data.

For the purposes of this discussion, there are two sections in the new Guidelines that affect E code reporting; section I.C.17.b.1 (Acute Fractures vs. Aftercare) and I.C.19.a.2 (General E Code Coding Guidelines).

The update to the Guidelines regarding Acute Fractures vs. Aftercare in section I.C.17.b.1 clarifies the distinction between "active treatment" and "aftercare."

The Guidelines at I.C.19.a.2 state: "*Assign the appropriate E Code for the initial encounter of an injury, poisoning, or adverse effect of drugs, not for subsequent treatment*," however, the November 15, 2006 changes add the following language: "*External cause of injury codes (E codes) may be assigned while the acute fracture codes are still applicable*." The issue here is that assigning E codes during all phases of active treatment could easily result in redundant E code assignment. When taken in the context of the intended purpose of E code reporting, this practice would degrade the quality of the data.

For the purposes of Arizona hospital discharge data reporting, it is important to understand that "initial encounter/initial treatment" and "active treatment" are **not** the same. Initial encounter/treatment is the *first* time the injury is treated, while "active

treatment" could continue in the second or even third visit, in the form of a fracture reduction or evaluation by an orthopedic specialist in preparation for reconstructive surgery.

E codes are currently required by ADHS on the *initial* encounter for injuries, poisonings and adverse events/reactions. The new language of the Guidelines will **NOT** affect this requirement.

To summarize:

ADHS requires the E code for the cause of occurrence on all records for initial encounter/treatment of a patient with a Principal Diagnosis of injury/poisoning/adverse event or reaction. The ADHS definition of “initial treatment” means the first time the condition is treated. Therefore, if the patient is treated in the emergency department of Hospital A, and then is transferred to Hospital B, we would expect to receive the E code from Hospital A but not from Hospital B. Although the patient in this example probably received the most comprehensive treatment at Hospital B, this is not the initial encounter/treatment. To expect hospitals to somehow “know” on transferred patients where the most comprehensive treatment was/will be received is neither reasonable nor practical. For this reason (and based on the Guidelines), ADHS requires E Coding on the *initial encounter.*

This same guidance also applies to the assignment of place of occurrence E codes (on records where a place of occurrence is appropriate).

Please distribute this information to all hospital staff involved with or affected by the coding or state data reporting processes.